IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF NORTH CAROLINA

CIVIL ACTION NO. 3:22-cv-00191

KANAUTICA ZAYRE-BROWN,)
)
Plaintiff,)
)
vs.)
)
THE NORTH CAROLINA)
DEPARTMENT OF PUBLIC)
SAFETY, ET AL.,)
)
Defendants.)

DEPOSITION OF

SARA BOYD, PH.D.

9:08 A.M.

FRIDAY, AUGUST 4, 2023

NORTH CAROLINA DEPARTMENT OF JUSTICE

114 WEST EDENTON STREET

RALEIGH, NORTH CAROLINA

CONTAINS GENERAL CONFIDENTIAL INFORMATION

the -- the vulvoplasty or vaginoplasty that she wants. So those are the four primary opinions that I offered.

Q. Okay. You say primary opinions. Are there other opinions in here?

A. Well, the -- you know, for example, when I say that the con- -- Dr. Ettner's process was undermined by deficiencies, there's, like, secondary, you know, critiques to that that are --

Q. Uh-huh.

A. -- covered under that umbrella is what I mean.

Q. Okay. All right. I'm going to flip to Page 33 and I'm looking at Conclusion Number (1)(a). You write, A psychologist who lacks formal medical education and training should not offer medical opinions, e.g., medical necessity, or state that their opinions are reliable and valid to a reasonable degree of medical certainty.

Did I read that right?

A. Yes.

Q. All right. What is your basis for this opinion?

A. Ethically, we're obligated not to offer opinions that are outside the bounds of our competence and our training. If you're not a medical provider, you shouldn't be giving a medical opinion. So, for example, if I'm testifying in court and someone asks me to give an opinion that's fundamentally a neurological opinion --

Q. Uh-huh.

A. -- or a -- a question about, well, if we gave this person this medicine, do you think it would make them feel better, I can't answer that question because I'm not a medical doctor and that's what I would say is, that's a medical question. You need a medical doctor to answer that. It's outside the bound of my com- -- bounds of my competence as a psychologist.

Q. Okay. And you said it -- it -- it's an ethical matter. Is there a -- you know, a published ethical code that you follow?

A. Yes. So there's APA ethics code and then there's -- they call them guidelines. They're all guidelines, but the -- there's a forensic specialty guideline ethics code as

well.

Q. Okay. So are -- are you providing an opinion in this case on medical necessity?

A. No.

Q. All right. In your view, can a psychologist like yourself or Dr. Ettner ethically provide an opinion on whether something is psychologically necessary or perhaps, as you put it, can provide a psychological benefit?

A. Yes.

Q. All right. I'd like to spend a little bit more time on that term. What does -- what does it mean for something to have a psychological benefit or to be psychologically beneficial?

A. Right. So --

MR. RODRIGUEZ: Objection.

A. -- typically, we're talking about treatment in this context, right, some kind of intervention that would be delivered to the person. So beneficial generally refers to either we're managing the person's symptoms so that they don't get worse or we're actually ameliorating the symptoms so that they improve, which might not mean that

they're cured and it might not even mean that they no longer meet diagnostic criteria for it, but they might have a significant relief in terms of the emotional pain that they're experiencing or cognitive limitations or behavioral problems that they're having. In some cases it can, you know, kind of at the extreme be essentially curative whereby the symptoms are ameliorated to the point that you fall below the diagnostic threshold. You may still have some persisting symptoms that are bothersome to you, but you no longer meet criteria. Occasionally, there are interventions that can be essentially curative, but for many psychological conditions, we often don't necessarily think of them as being cured but, rather, in remission because of the tendency that a lot of psychological conditions have to come back.

Q. Uh-huh. And so psychologically beneficial would encompass all of those things that you just mentioned; is that right?

A. Yes.

Q. Okay.

A. But it's still important to make the distinction because we don't want to assume that because something is psychologically beneficial that that also makes it curative.

Q. Okay. And I think you told me what curative means a moment ago, but can you tell me again what -- what does it mean to be curative?

A. Well, curative is not a technical term.

Q. Uh-huh.

A. But essentially, what we mean is that there's either a condition where the person's symptoms drop below the level that's required -- the threshold that's required for a diagnosis, right. We use this Diagnostic and Statistical Manual. It has criteria that you have to satisfy in order to have a -- meet criteria to have a certain condition. You know, let's say that you have to have four of those criteria. With significant, you know, benefit from psychological treatment, you may drop down to only having two of them. You still have those two things. They might be bothersome to you, but because you don't have four, you don't qualify for the disorder anymore. So I would

not consider that curative; I would still consider that to be an amelioration. Curative would be you have no symptoms of the condition.

Q. Understood. So is there a difference between a treatment being psychologically beneficial and medically necessary or medically beneficial, whatever the correct term is?

MR. RODRIGUEZ: Objection, medical opinion, but you can answer.

A. Yeah. There is a difference and that's why I don't -- that's why I can give an opinion about benefit without giving a medical opinion. So, you know, if somebody asked me, you know, if this person has electroshock therapy, will their depression be cured, I wouldn't be able to give an opinion about that. What I could give an opinion about is, here's what seems to be contributing to their depression. Here's what parts of it appear to be biological or sort of mechanical issues with their brain.

Q. Uh-huh.

A. But here are the other things that may not be. And so here's why we have reason to

believe that the person may need more than ECT.

Q. Okay. When it comes to gender-affirming surgery, in your view, can that ever be -- or could it ever be psychologically beneficial but not medically necessary?

MR. RODRIGUEZ: Objection, medical opinion. You can answer.

A. So saying something's not medically necessary would be giving an opinion about medical necessity so I would not give that opinion. What I would endeavor to do instead would -- to be very clear about for psychological benefit, you know, what does that mean, when, how, who, what.

Q. Uh-huh.

A. What are the circumstances where the person is most likely to achieve the best psychological benefit that they can get. I wouldn't give an opinion about, you know, this surgical technique versus that surgical technique or this medication versus that medication.

Q. In your experience, in your training, are you aware of any patient who was seeking

gender-affirming surgery and their providers determined that, yes, it's psychologically -- it would be psychologically beneficial, but, no, it wouldn't be medically necessary?

A. I'm not typically privy to how the internal committees within the Virginia -- for example, Virginia DOC make those kind of determinations so I don't usually even know what necessarily happens in terms of the endpoint of those cases. So I'm not sure what kind of determination was made by those kinds of panels.

Q. Okay. So in your view, who would be qualified to make a determination on medical necessity for gender-affirming surgery?

MR. RODRIGUEZ: Objection, medical opinion, outside the scope of this expert's opinions. You can answer.

A. So if some were to -- someone were to ask me for a referral for that, I would say it would need to be a medical professional, but the type of medical professional could depend largely on the individual person, what their needs were and what they were asking for. So a lot of times, an interdisciplinary approach

is a pretty helpful one for that where you've got a couple of different kinds of medical doctors so you might have an endocrinologist as well as a surgeon and a psychiatrist, for example.

Q. And do you have a sense of how a medical provider would go about determining whether surgery's medically necessary?

MR. RODRIGUEZ: Objection, medical opinion, speculation. You can answer.

A. I don't feel enough -- I don't feel that I know enough to say whether or not I know enough about that. I'm not -- I'm not familiar enough with the decision-making processes that they utilize for medical necessity to be able to give an opinion about that.

Q. Okay. Are you familiar at all?

A. I've certainly read depositions where physicians were discussing medical necessity. The -- I don't think that I'm an expert on medical necessity. I wouldn't give an opinion about medical necessity.

Q. Okay. Let's flip to Page 5 of your report.

A. Uh-huh.

Q. So I am in the second paragraph, last sentence, and you write, I know other psychologists like Dr. Ettner and I who also perform similar evaluations related to gender-affirming care for transgender and gender-nonconforming individuals and, in my experience, it would not be typical for them to offer medical opinions.

Did I get that all right?

A. Yes.

Q. All right. Who were the other psychologists you're referring to?

A. So one would be Dr. Olezeski and her colleagues at the Yale clinic. These are the -- some of the folks that I was thinking of in particular because they conduct a lot of trainings. The last one they did was for the APA last year and although they don't offer medical opinions, they work collaboratively with medical doctors so they're not completely siloed off.

Q. Uh-huh. Anyone other than Dr. Olezeski, if I'm pronouncing that correctly?

A. Yes, you are pronouncing that correctly. So Sarah Miller, my coauthor. I don't believe

Dr. Campbell has offered those opinions, who's also my coauthor on that chapter.

Q. What is Dr. Campbell's first name?

A. Walter.

Q. Okay. So you say it's not typical for them to offer medical opinions. Do they ever offer medical opinions?

A. I can't say that I know enough about all of those individuals and everything they've ever said or did to be able to say they have never offered an opinion that I would not consider to be a medical opinion. So I can't -- I don't think I have the foundation and knowledge to answer that, but my understanding in my interaction with those folks is that they would -- their ethical principle would be not to offer one because it's outside the scope of their competence --

Q. Uh-huh.

A. -- and I've never known them to do that.

Q. Okay. So for this assertion in your report -- excuse me, your report concerning offering medical opinions when you're a psychologist, are you relying on anything beyond your personal professional experience?

A. Well, so we have authoritative texts that provide guidance on these topics. We -- there's a -- Mental Health Evaluations for the Courts by Melton and colleagues is sort of one of our foremost texts that we would cite to that talks specifically about the importance of maintaining -- staying within the bounds of your competency as a psychologist. This is reiterated in our ethics code broadly, in our forensic guidelines more narrowly. Additionally, you'll see this in virtually any discussion of forensic psychological practice because it's not just that we shouldn't give medical opinions -- that's one pitfall, one kind of potential land mine for us.

Q. Uh-huh.

A. -- but also that we ought not offer legal opinions. That's the other area where we're significantly cautioned is not to offer legal opinions unless we are -- you know, like I said, I have colleagues who are J.D./Ph.D.s. that they might, but if you're just a psychologist, you would not. So it's not specific just to medicine.

Q. Okay. And these authoritative texts, do they say specifically something along the lines of, you know, forensic psychologists cannot, should not make recommendations concerning medical necessity?

A. I don't have a specific recollection that that -- the exact language regarding medical necessity. I would have to look at the text and see if that's an accurate representation of what they say.

Q. Yeah. Well, I mean, I don't expect you to remember offhand exactly what it says.

A. Uh-huh.

Q. Do you recall that it says something like that?

A. No.

Q. Okay.

A. I don't have a recollection.

Q. Okay. So can a psychologist, in your view, refer a patient -- can a psychologist refer a patient seeking gender-affirming surgery to a medical provider?

A. Yes.

Q. Okay. That's permitted by WPATH standards?

A. Well, in fact, WPATH talks about an

interdisciplinary approach at times. But an interdisciplinary approach could come because somebody goes to a clinic and the clinic takes an interdisciplinary approach or they could come to an individual psychologist or other mental health care provider or even their doctor and that person could refer them for intervention.

Q. Okay. So in terms of just what a -- a patient's care looks like --

A. Uh-huh.

Q. -- in your view, it's appropriate for a psychologist to conduct an evaluation, say, I think this treatment, surgery, or whatever would have psychological benefit, and I'm going to refer you along to a surgeon, endocrinologist, whoever?

A. Right. You -- I mean, you would also typically discuss whether or not a diagnosis of gender dysphoria is present or absent.

Q. Okay. All right. So still on Page 5. Bear with me just one moment. All right. I'm sorry. So this is second paragraph and it's four lines down. Thus, my role in such cases is not to make determinations regarding

whether a person should or should not receive a given intervention.

Did I read that correctly?

A. Yes.

Q. All right. And then let's flip to Page 2. And you say that part of your role is to offer recommendations with respect to gender-affirming interventions; is that right?

A. Right.

MR. RODRIGUEZ: Can you --

MR. SIEGEL: I'm sorry.

MR. RODRIGUEZ: Where are you -- yeah, where are you reading?

MR. SIEGEL: I'm sorry. Where is it? I don't have it highlighted on my copy.

BY MR. SIEGEL:

Q. Sorry. Bear with me just one moment, y'all.

MS. MAFFETORE: It's the first line --

MR. SIEGEL: Okay.

MS. MAFFETORE: -- on the second page, to offer recommendations with respect to --

MR. SIEGEL: Okay. Thank you.

MS. MAFFETORE: -- gender-affirming --

BY MR. SIEGEL:

Q. All right. So it's -- yeah. It's the very first line after the comma, Part of your role is to offer recommendations with respect to gender-affirming interventions or building capacity to provide informed consent.

A. Uh-huh.

Q. All right. So did those statements that I just read, the one on Page 2 and the one on Page 5 -- is there any contradiction between those statements?

A. I think part of the difficulty that we're having here is that we're maybe confusing making recommendations with respect to gender-affirming interventions with recommending specific gender-affirming interventions.

Q. Okay.

A. So what I don't do is I don't say, this person needs to have this surgery or this person should not have this surgery. I don't --

Q. Uh-huh.

A. -- say either one of those things.

Q. Okay.

A. But what I might say is, you know, what this

person has articulated is that they would like to -- you know, for example, I might say, I think they should be provided with information about what their options would be for bottom half surgery because what they've described in terms of their ultimate goal might necessitate that based on how they've described the presentation that they want. So I might recommend, for example, like, they should be provided with more information about that and here's how they should be provided with that information. I might say, they would learn best -- if they're a bright person who likes to read, maybe give them a book. If they're not or they have literacy problems, I might make recommendations that are different. So it's not that I'm recommending what interventions they should have, but I'm providing recommendations related to gender-affirming interventions without saying that they should or should not have them.

Q. And so in this case, you -- are you providing an opinion whether Mrs. Zayre-Brown should or should not receive a certain treatment?

A. I haven't given an opinion about whether or not she should -- from my perspective she should or should not receive a given treatment, but what I have done and can do is describe what she has said she wants.

Q. Okay.

MR. SIEGEL: Let's take a short break, if that's all right with y'all.

MR. RODRIGUEZ: Yeah.

(Whereupon, there was a recess in the proceedings from 11:00 a.m. to 11:09 a.m.)

BY MR. SIEGEL:

Q. Welcome back, Dr. Boyd.

A. Uh-huh.

Q. All right. Changing gears somewhat. Are you familiar with the Division Transgender Accommodations Review Committee or DTARC?

A. I am familiar with their existence. I'm familiar with them to the extent that their activities were documented in the records that I reviewed, but I don't have independent knowledge of them outside of the information I reviewed in this case.

Q. Okay. So based on what you reviewed, excuse me, what is the DTARC?

A. It's a committee that I believe reviews requests and then provides approvals for various stages of the process. So there are administrative processes for approving evaluations, scheduling consultations, and then approving procedures.

Q. Do you know who's on it?

A. No.

Q. Are you familiar with their decision last year to deny Mrs. Zayre-Brown's request for gender-affirming surgery?

A. Yes.

Q. Do you have an understanding of how DTARC reached that decision?

A. No. My primary focus was about how Mrs. Zayre- -- Zayre-Brown received the news and responded to it --

Q. Okay.

A. -- more than the deliberation.

Q. Okay. I'm going to hand you another exhibit. I think this is Exhibit Number 3 that we're on.

(BOYD EXHIBIT 3, Division Transgender Accommodation Review Committee (TARC) Report, 2/17/2022, was marked for identification.)

BY MR. SIEGEL:

Q. Dr. Boyd, have you seen this document before?

A. This actually may have been included in the records that I reviewed. This front page does not look fam- -- as familiar, but the -- the second and third page does.

Q. Okay.

A. Although it's possible that it looks familiar because it was cut and pasted from another section of the records. That often happens.

Q. Okay. So take another moment to review if you'd like --

A. Sure.

Q. -- and then just let me know what this document is --

A. I will tell --

Q. -- or appears to be.

A. Yes. So this appears to be a report that documents a determination that was made by the -- the Division Transgender Accommodation Review Committee. So it documents what information they reviewed. It provides a brief narrative and a medical analysis is the latter portion. It details who was in attendance at the time of the meeting and on

the front -- on the cover sheet there's an indication that the purpose of the review was related to gender-affirmation surgery/vulvoplasty and the accommodations referred for final determination includes the decision that says, DTARC does not recommend gender-affirmation surgery stating, This surgery is not medically necessary.

Q. Okay. I think that sums it up. Are you familiar at all with the professional background of the -- the individual defendants in this case?

A. No. Be- -- not beyond what their title is as reflected in records.

Q. Okay. Do you -- do you know if any of them have medical training?

A. I believe some do. I believe your -- that, for example, your chief medical officer is a physician.

Q. All right. Any of the others to your knowledge?

A. My -- well, typically, the chief of psychiatry would be a psychiatrist, who's also a medical doctor, so it's likely that person is also a physician.

Q. Okay. So based on this document, the DTARC recommended that gender-affirming surgery was not medically necessary, correct?

A. That's what the form states, yes.

Q. Okay. So if any of the members of the DTARC who participated in this recommendation did not have medical training, would that have been appropriate in your view?

MR. RODRIGUEZ: Objection to form. You can answer.

A. So that's a -- this is a good example of why the interdisciplinary approach is important. So you can see there's a medical analysis section that -- there's a heading specific to that. I would suggest that someone without a medical degree should not be involved in the decision-making regarding, like, the deter- -- the actual determination as far as saying this is medically necessary or not. However, it may benefit the folks who have the background to men- -- make the medical determination to have the input from folks who have a background in mental health and/or who are administrative folks who know more about what the internal regulations and

requirements are so they can have input and they may provide information that the folks who make the medical determination find relevant and necessary. But as far as who signs off on the medical analysis and who drafts it, in my opinion, that should be a physician -- it should be someone with a medical degree.

Q. Understood. Okay. You can set this aside if you'd like. So a lot of your report is talking about informed consent and you've spoken about that some today. I'll just ask a very basic question of what is informed consent and why does it matter?

A. Right. So informed consent, broadly speaking, refers to the necessity for individuals who are participating in treatment or evaluation to knowledgeably agree to participate or receive that treatment or evaluation. So that's, like, in the very broadest sense. And informed consents in our practice as psychologists means that people are knowingly participating in -- whether it's an evaluation or treatment, that they are a -- given the

opportunity to be provided with the information that they need to understand the risks and the benefits, the costs, and, you know, have a reasonable and reality-based appraisal of that before they are asked to make a decision. There's two parts to it. One is making sure they have the information. The other part is the autonomy of the individual to choose to participate or not.

Informed consent in terms of providing care to folks who are transgender has -- is slightly different. So we still have the core informed consent obligations that we're required to maintain ethically in terms of our practice, doing evaluations or -- or doing treatment, but informed consent is also, somewhat confusingly, the name of a different kind of approach to assessing individuals and providing treatment to individuals who are transgender, whether they're in the community or a carceral setting. It's not specific to a setting. And what it means is that instead of saying that our role is to decide if somebody is trans or not, instead, our role is to make

sure that the person not only has the capacity, right -- which capacity doesn't mean you already have all the information; it just means you have the ability to understand and process that information, make decisions. Not only do they have the capacity, but have they been provided with the information that they need? Are they in a position to make a decision about it and do they have the support that they need to do that? So an informed consent approach to conducting these evaluations is different even though it uses the same terminology as informed consent in terms of an ethical obligation on the part of psychologists when they're conducting activities involving patients, clients, or research participants.

Q. Okay. So when you are evaluating patients for informed consent meaning, I think -- well, let -- I'll let you answer that. When you're evaluating a patient for informed consent, which one of those do you mean --

A. Right.

Q. -- and how do you do it?

A. Right. Well, unfortunately, another

complicated answer.

Q. Okay. Great.

A. So one version of looking at this could be, like, a Miran- -- a competency to waive Miranda evaluation, which is retrospective and it's looking at whether or not the person knowingly, intelligently, and voluntarily waived their rights to a custodial interrogation so you might look at their capacity. Do they have an intellectual disability, do they have a severe psychiatric problem, were they under severe stress, things like that. So that's one area where it's -- you know, that's one area where it's different.

But informed consent in this process refers more to positioning the individual who's seeking treatment in such a way that they can access the support that they need, have the information that they need delivered in -- to them in a way that they understand so that they can make a decision collaboratively with their treating professionals about what treatment they need, when they should get it, how it should be

delivered.

Q. In this case did you assess Mrs. Zayre-Brown's ability to provide informed consent?

A. I used an informed consent approach and part of that was assessing her capacity to provide informed consent and I did ultimately come to an opinion regarding that.

Q. Okay. How did you go about making that assessment?

A. I looked for the presence of any conditions that could potentially interfere with her capacity to provide informed consent and then I just asked her direct questions to ascertain her fund of knowledge and her beliefs about different kinds of scenarios and options.

Q. Okay. Could you be a bit more specific on --

A. Certainly.

Q. -- how you did that.

A. Yes. So in reviewing her records, for example, I looked for conditions that could be expected to potentially, even just in a time-limited way, impair her capacity to provide informed consent. So I looked at

mood issues, cognitive issues. Those are the -- those issues and psychosis are the most common kind of barriers to that.

After you see whether or not those things are present, if they are present, then you look to see, are they relevant? In other words, are they active now when the person -- or during the relevant time period when you're looking at the decision-making, which for Mrs. Zay- -- Zayre-Brown is now.

So she does have some cooccurring conditions. You know, in my view, though, at the time that I saw her, those symptoms were not so active or impairing that they would impair her capacity to understand what her options are and make decisions.

Q. Okay. Does that mean you concluded that she can provide informed consent?

A. I believe she has the capacity to provide informed consent in that, you know, narrow -- more narrow kind of ethical obligation of ensuring that she's not, for example, agreeing to a procedure when -- in a -- without a reality-based understanding.

Q. Okay. If you could flip to Page 31 of your

report. And this is beginning of Section E. Sorry. I'll wait till -- for you get there.

A. Yes.

Q. Oh, I'm sorry. It's actually the -- the first full paragraph on the page, which reads, Mrs. Zayre-Brown's expectancies for the surgical aftercare that would be available to her in prison were less realistic in light of history.

What does that mean?

A. So this interview was -- was video recorded.

Q. Uh-huh.

A. And this is a reference in part to the discussion that Mrs. Zayre-Brown and I had about her experience when she initially entered custody and had had surgery about a month before that -- be- -- before her sentencing. And so she was still recovering from a surgical procedure and that's where the -- part of where that relevant conversation started. We discussed what care she had already received and that's why I say in light of the history. When I say that her expectancies for surgical aftercare that would be available to her in prison were less

realistic, I say that because what she was describing in terms of what she expected to receive in terms of aftercare was a radical departure from what -- the care she described actually receiving.

Q. Okay. And the care that she described receiving with respect to recovering from the orchiectomy --

A. Yes.

Q. -- in 2017; is that correct?

A. Yes.

Q. All right. Was there a -- anything else in your assessment that contributed to your statement here that her views were less realistic about aftercare?

A. So here we're talking about surgical aftercare specifically --

Q. Uh-huh.

A. -- so not other elements of aftercare. And, yeah, so that particular statement is related to that discussion.

Q. Okay. And so my question is, was there any other statement that she made or any other part of your assessment that contributed to that observation you made?

A. The result of her formal testing by me --
Q. Uh-huh.
A. -- indicate that she has a personality style where she is -- she has a tendency to, like, idealize situations sometimes that are prospectively positive so that can cause her to be a little bit like a cork on the ocean where a good thing happens or something seems like it's going to be really promising and relieving and her mood goes up significantly. At the same time, when she gets news that something is not going to happen, her mood can drop down really dramatically. And in my view, that affects her ability -- when she's in those states, that does affect her ability to accurately appraise and anticipate what's going to happen in the future, but that could happen in either direction depending on the circumstance. I think this is an example of her idealizing what would be available to her. And I say idealizing it because she is com- -- I'm comparing it to what she has told me about her own experiences prior to that.
Q. Uh-huh.
A. And she was not able to provide me with

information that was -- would indicate that there were -- there was an evidence base for believing that the circumstances that she described as ideal for her and most likely to give her relief and benefit would actually happen in a prison setting.

Q. And what would be ideal?

A. So she articulated it herself and I describe it on that same page, the last paragraph before Section E. Her idea -- her view of an ideal surgery context would include, A, receiving medical care in the community, including aftercare and wound care management; B, the opportunity to receive care and support from her husband, friends, and family; and, C, participating in meaningful personal and professional development opportunities while she is preparing for surgery and recovering from surgery.

So this is her statement about what she sees as an ideal surgery context. Now, when I say she idealized things, I'm -- here that's not what I'm talking about. This is her -- just her self-report, her description

of what she thinks would be optimal for her --

Q. Okay.

A. -- clinically. What she described as far as what -- how she thought recovery -- what recovery from this procedure could look like in a prison setting, she described having more access to physicians, more regular care than she described having at the time that she initially entered prison in 2017.

Q. Got it. Do you have an understanding of what postsurgical care is like for a vulvoplasty?

A. I have some familiarity, but I can't give a medical opinion.

Q. Okay. I'm not a asking for a medical opinion, just to your knowledge. Is -- is it anything more complicated than basic wound care?

A. It depends on the individual. The vulvoplasty differs from vaginoplasty in that most individuals, you know, there wouldn't be a reason to use dilators, for example, but depending on how the procedure is done, how skillfully it's done, what the individual's history is -- she did have complications

through her wound care before from the orchiectomy but -- you know, it can be complicated for individuals, but it -- you know, it depends on the person. All I can rely on for her -- from her is what she tells me about what her prior experiences were with her ability to manage wound care. And I think it is fair to say that it's certainly a risk, probably a more significant risk for vaginoplasty compared to vulvoplasty, but both of them would carry risks and a physician would have to be the person -- a surgeon would have to be the person to give you an opinion.

Q. Okay. So other -- other than her experience in 2017, do you have any other reason to be concerned about the quality of aftercare provided in the state prison system?

A. I'm re- -- again, I'm relying on her report.

Q. Okay.

A. I'm relying on what she has personally experienced and the aftercare that's available in one facility or for one individual could be different even within the same prison system.

Q. Speaking very generally, do you have concerns about the quality of care offered in the prison setting versus the community setting?
A. With respect to mental health care, which is really what I'm able to comment on, yes.
Q. Okay. Could you tell me why.
A. Prisons are inherently stressful environments. Restrictive housing in particular is a highly stressful environment. It's well documented that it's incredibly psychologically stressful.
Q. Uh-huh.
A. The analogy I sometimes give is that depending on where you're at in the prison is the psychological equivalent of getting hit in the head -- or getting -- yeah, getting hit in the head with a hammer every day and wondering why your skull isn't recovering. You know, you could get medical treatment --
Q. Uh-huh.
A. -- you could get stitches, but if you're still getting hit in the head with a hammer every day, you're not going to get a lot better. And that's part- -- partly an issue of confinement. It's partly an issue of who

you're around, what your population is and -- and who your social community and your peer group is and whether they're dangerous to you or not. But from a mental health perspective it is -- you know, we would most -- I don't know any psychologist who would say that it's not a -- a psychologically stressful environment.

Q. Uh-huh.

A. So there's that aspect to it. Doesn't mean the community can't also be stressful. Being unhoused --

Q. Uh-huh.

A. -- for example -- you know, there are all kinds of ways that the community can also be stressful, but just as a baseline, it's a more stressful environment. Sometimes people have access to services in there that they don't have access to in the community, but overall just as a baseline, it's a different environment from a psychological perspective.

Q. Okay. So I'm going to give you a hypothetical. In your view, assuming that a treatment would be psychologically beneficial for a patient and is medically ne- -- excuse

me, medically necessary, would the quality of aftercare available be a valid reason to deny that treatment?

MR. RODRIGUEZ: Objection to form, medical opinion. You can answer.

A. Denying the treatment would be an administrative decision. It's not -- and that's not a process that I'm part of. I also think that the individual's perspective on whether they feel they could tolerate, you know, those circumstances would be something to take into account. It's difficult to answer that hypothetical just because it is somewhat broad.

Q. Okay. Well, I'll narrow it a little bit. So you can also assume that this person has requested the surgery and has been seeking it for years. And I'm not talking about really the administrative decision. I'm talking about a decision by the healthcare providers treating the patient. So assuming all of that -- so we've got patient who wants a treatment. Assume that it's psychologically beneficial. Assume that it's medically necessary. Patient has been advocating for

herself for years.

In that case, would the quality of aftercare available be a valid reason to deny the treatment?

MR. RODRIGUEZ: Objection, medical opinion, legal opinion, speculation, form. You can answer.

A. I wouldn't say -- I wouldn't say that exactly, but I would direct you to, actually, Ettner's second declaration, Paragraph 38 where she describes a Cornell study regarding outcomes for transgender folks after they've had procedures done and one of the things that predicts outcomes is the quality of the surgical procedure and, I believe also, the aftercare that's available to that individual. That does affect the outcomes that people have.

Now, you know, there's critique -- there's different ways to talk about that and think about that. Regret rates are also related to the fundamental effectiveness of the surgical procedure and whether or not the person ends up with the outcome that they want. Now, as I'm sure you know, regret

rates are very, very low, but even within that group, one of the things that does predict it is if you don't get the surgical outcome that you want physically.

Q. All right. So getting back to Kanautica and informed consent --

A. Uh-huh.

Q. -- were there any aspects of informed consent that you assessed and haven't mentioned yet today?

A. Yes. I discuss in my report -- and forgive me one second. I want to locate it, the section. Okay. On Page 10 in the section that has a header that starts with, Dr. Ettner discounts the importance of a psychologist's role in informed consent, the second full paragraph, A prospective patient's understanding of the likely outcomes of a procedure and the timing of these outcomes is key to their ability to make decisions while also weighing the risks and costs. Skipping down a little bit to the second-to-last sentence, for example, a patient who believes an intervention will be curative may accept more serious or higher

probability risks compared to a patient who believes that an intervention will alleviate but not cure their symptoms. Communicating to a prospective patient, continuing on to the next page, Page 11, that a surgical procedure will be curative carries significant risk of misleading the individual and influencing their decision-making with inaccurate information leading to exaggerated proc- -- expectancies.

And so here what I'm speaking about, and I continue to talk about in the report, is the narrative -- is the information essentially that Dr. Ettner provided to Mrs. Zayre-Brown saying, this will cure your gender dysphoria. That is something that I did get into and I discussed with Mrs. Zayre-Brown because of my concern that if doctors are -- authority figures are coming in and telling her, this will cure your gender dysphoria, and that's not true or at least we can't say it with that degree of confidence that that's definitely what's going to happen, then that person may decide to undertake procedures under riskier

circumstances, less optimal circumstances that are likely to produce less benefit because they think, this is what's going to fix the pain that I'm experiencing. And so I do certainly have that concern and I discuss it in my report with respect to informed consent, wanting to ensure that Mrs. Zayre-Brown has accurate, reality-based information so that -- so that she can make her own decision.

Q. Are you expressing an opinion in this case as to whether Mrs. Zayre-Brown has actually provided informed consent for gender-affirming surgery?

A. I gave the opinion that I don't believe her capacity to provide informed consent was significantly compromised at the time of my evaluation of her so her capacity to provide informed consent to most surgical procedures at this point, I think, is probably intact.

I mentioned the information that I think has been provided to her that is misleading and I -- you know, obviously, I want to make sure she knows that that is my perspective so she has that information, too, in making her

such as gender dysphoria, which has a diverse manifestation and is inextricably bound up in aspects of the person's life and circumstances that go far beyond the physical appearance of their genitals.

Did I read that right?

A. Yes.

Q. All right. So big picture question. Like, can gender dysphoria be cured?

A. I think there are certainly people who could get to the point that they would be subthreshold, right. That's an -- I -- I've talked before about how there's difference between subthreshold and having no symptoms. I think certainly for most people, there's the possibility of bringing somebody subthreshold for gender dysphoria, but it's usually not the case that there's a single intervention that's sort of like a magic bullet. It's usually a combination of things that deal with, you know, as I allude to here, not just what their genitals look like or their secondary sex characteristics but also what their social environment is, what their supports are --

Q. Uh-huh.
A. -- what their access to care -- all kinds of care is.
Q. Okay. So why is it that a -- a psychologist can't predict that a certain intervention will be curative of gender dysphoria?
A. Because of the fact that it -- there's so -- there's other contributing causes. I mean, like, really just what I said there. It's not just about the -- the appearance of somebody's physical body. There are other factors there. So it's more like I'm saying there's not one thing most of the time. And for her specifically -- getting into her specifics, she articulates repeatedly that there are other factors that contribute significantly to her gender dysphoria, specifically transphobia that she encounters from other people and also to some degree, I think, internalized transphobia when she feels that she's been recognized and identified and then treated differently because she's a trans woman.
Q. In your view, can a psychologist predict with confidence that a certain intervention

wouldn't be curative but that -- but that it's necessary to achieving a cure?

MR. RODRIGUEZ: Objection to form. You can answer it.

A. We would call that necessary but not sufficient --

Q. Uh-huh.

A. -- in -- in our terminology. So it's a piece of it, but it's not going to get you all the way there is the idea. That's one way of looking at that, yeah.

Q. Okay. Would that be true for any clinical psychologist?

A. I'm sorry. I -- can you ask that question in a different way?

Q. Would it be true for any clinical psychologist --

A. That --

Q. -- that you cannot predict that a certain intervention will be curative?

A. I think it depends on the intervention and it depends on the individual.

Q. Okay. Well, how -- how about yourself, would that apply to you?

A. Well, yes. I mean, I think it would depend.

If I have somebody that it's a very straightforward presentation and they -- let's say they have very physiological depression symptoms, in other words, they feel very tired, they have very little motivation, they can't -- just can't move their body to do the things that they need to do. Provided that there isn't an underlying medical condition and that's been ruled out through interdini- -- disciplinary practice or referral, then I would say we have good reason to believe that probably about 80 percent of people would achieve remission is what we would call it for -- for a condition like that. So I could tell -- I wouldn't tell somebody, I'm absolutely confident this will cure you.

Q. Uh-huh.

A. You know, something else could happen. Their parent could die. They -- you know, any number of things could happen that could interfere with their progress, you know, but I could say, you know, given the evidence base for the success rate of this intervention, given the complexity or lack of

complexity in your presentation, you know, here's how likely I think it is you would benefit, but I would never tell somebody, I am certain that this will cure you.

Q. Okay. Let's flip to Page 20. So I'm going to -- the last sentence of Subsection B you say, Likewise, surgical intervention alone is not likely to be curative and may not substantially ameliorate her suicidality --

A. Uh-huh.

Q. -- is that right?

A. Right.

Q. Okay. So are you making a prediction here about whether a certain treatment would be curative?

A. I think it's not likely it would be curative. I do -- I think it's likely she would achieve a benefit from it. It's really -- I think the debate is sort of the degree of that benefit. Secondarily, you know, the question of, like, substantially ameliorating her suicidality, I mean, it might, you know, but I don't think that we have confidence to say it will.

Q. Do you see any tension between your assertion

here and the assertion we spoke about a moment ago that a psychologist cannot predict with confidence that a certain treatment will be curative?

A. Yes, but that's basically making -- that's saying, this is -- this is how this is going to go. What I -- what I'm saying instead here when I'm saying it's not likely to be curative is -- what I'm saying is the most likely outcome is that it's going to fall short of that particular benchmark of being curative. Doesn't mean -- I'm not saying surgical intervention alone is not likely to provide psychological benefit or amelioration of the symptoms, but it's not -- I don't think it's likely to be curative specifically. That's a very high bar.

Q. Okay. But do you think that gender-affirming surgery would provide psychological benefit to Kanautica?

A. I think depending on the circumstances, if it's provided in the way that she details, which I described in my report on Page 31, receiving medical care in the community including aftercare and wound management,

receiving care and support directly from her support network, participating in meaningful personal and professional development opportunities both while she's preparing for it and while she's recovering from it, then, yeah, I think she -- I have no problem at all saying I think it's likely she would benefit from that and probably, I think, get significant relief both with respect to gender dysphoria and with respect to suicidality.

Q. Okay. Are you familiar with the treatments for gender dysphoria she has received so far?

A. I don't want to misrepresent my level of understanding. I have some understanding of what she's already undertaken, but I don't have a medical professional's level of knowledge.

Q. Okay. Do you know that she has been on hormone therapy?

A. Yes.

Q. Okay. Do you know that she has un- -- undergone social transitioning?

A. Yes.

Q. Okay. To your knowledge, have those

treatments cured her of gender dysphoria?

A. No.

Q. Okay. Other than surgery, is there any treatment that you're familiar with for gender dysphoria that she has not received?

A. So medical treatments, I couldn't speak comprehensively to that because I'm not a medical expert so I can't tell you what all of those options would be. I don't believe that she's done voice training. That's something that she could do. There might be other kinds of sort of plastic surgery-type interventions that she might want, but, you know, those are -- you know, the -- the surgery aspects are a medical intervention. And additionally, there -- this is such an evolving area of practice that there are new procedures all the time so the options today might not be the options next year. There could be other things that would help her.

She had -- she -- and she has had plastic surgery from what I understand in terms of what I discussed with her in her deposition, but when you read her description of it and talked with her about it, she

describes getting very, very limited gains from these prior medical interventions.

Now, you know, one of the questions would be if she got such limited benefit from the prior interventions, why do we believe we're going to make the jump to a hundred with the -- one single intervention, you know? I don't think there's a -- I don't think we have good reason to believe that based on her own characterization and recollection of her experiences with medical intervention.

Q. Uh-huh. So zooming out somewhat, like, big picture, what do you believe is causing her gender dysphoria?

A. So Mrs. Zayre-Brown has had a very -- from my understanding she has not had an easy life. She does have support in her marital relationship and evidently her family relationships, but living as a transgender person in the United States at this point in time is painful and difficult not only because of constraints on access to services or people not even knowing what's available to them sometimes or not being able to afford

it, but also, obviously, there's a cultural environment that's hostile to people and I believe that that cultural environment is a significant cause and contributor to her gender dysphoria.

On top of that, frankly, our gender binary is -- is highly, highly determined by essentially the -- the ancestry's eugenics and the beauty standards for women are difficult for anybody to achieve and fairly narrow. And I think if the aim is to not be identifiable as a trans woman, that's going to -- that's difficult. And if you are identified, then it may be because of some piece of your anatomy that somebody knows about, but it could also be your height. It could be your shoulders. It could be your voice. People who aren't even trans are getting -- people are telling them that they're trans because their shoulders are too broad or their voice is too low. There are all kinds of ways in which she, I think, experiences transphobia in ways that have, frankly, nothing to do with her primary sex characteristics, but I also believe that

there is a contribution that is coming from her own internal discomfort with continuing to have a phallus when that is not consistent with her gender identity. I do think that contributes to her gender dysphoria and it makes sense then rationally that coping with that is going to be a sensible step for her in terms of treatment.

Q. And to be clear, what do you mean by coping with that?

A. Well, I mean having -- having a procedure to -- you know, having bottom half surgery, whether that's a vulvoplasty or vaginoplasty, dealing with that component of it, of the internalized transphobia. And also, just the discomfort, emotional and psychological discomfort, with continuing to have a phallus, that is its own contribution. I think that's valid. I believe her when she says that.

Q. Do you have any reason to think that Mrs. Zayre-Brown can be cured of her gender dysphoria while she still has a penis or a phallus as she calls it?

A. Based on her statements, I think not. I

believe her self-report has consistently been that this is something that she sees as sort of a keystone intervention. I think the main difference really is just that in my view, she needs other things as well and that we want to be careful and mindful about the timing and the setting and the context of intervention to maximize the benefit that she's going to get so we can get as close to the benefit as she anticipates as we possibly can.

Q. Okay. You mentioned the -- the phrase necessary but not sufficient a little while ago.

Would you say that removing her phallus and having genital surgery would be necessary but not necessarily sufficient to cure her gender dysphoria?

A. Ultimately, yes. The question of the timing, I think, is a separate issue, but in the long-term sense, yes.

Q. Uh-huh. Did you find any contraindications for surgery?

A. So I can't speak to medical contraindications for surgery. And surgery, broadly speaking,

no, but as far as what she described -- you know, that's what I keep coming back to is what she's describing as the set of circumstances that are going to -- going to give her the most relief.

Q. Do you have any reason to think that if she underwent a vulvoplasty, she would later regret it?

A. I think it's possible if the -- not in and of its- -- not, like, per se. Not only because of, oh, I wish I had had another procedure. It's possible depending how -- how the procedure went that later on, she could have some amount of regret, not that she had a vulvoplasty but that she didn't have a vaginoplasty instead. I think that's possible. I don't think it's likely that she would experience regret in terms of saying, I wish I still had a phallus.

Q. If someone undergoes a vulvoplasty, are they able to also undergo vaginoplasty later?

A. My understanding of it -- and I want to be clear because I'm not a medical professional. I can't give a medical opinion. But my in- -- understanding from consulting with

medical professionals who do the procedures is that vulvoplasty is a less commonly done procedure so it's -- most of the surgeons who would do it will have less familiarity with doing that compared to vaginoplasty and also that with respect to both the orchiectomy and vulvoplasty, there's the necessity of maintaining a certain amount of tissue and certain structures in order to be able to later do a vaginoplasty, although there are alternative procedures that can be done if that tissue isn't there, and they may be more or less desirable to the individual. I think it has to be a highly individualized medical decision that's made between the doctor and their patient.

Q. Okay. Let's turn to Page 29 of your report, please. And I'm -- it's the final sentence of the third paragraph on the page. In other words, Mrs. Zayre-Brown's acute mental health crises in recent years were indirectly rather than directly related to her gender dysphoria. Additionally, by her account, significant contributions to her distress were associated with administrative processes

and delays related to her treatment.

Did I read all that correctly?

A. Yes.

Q. What does it mean for something to be indirectly related to gender dysphoria?

A. So the idea would be that there's a certain amount of distress that comes from what I just described as this sort of compartmentalized -- it may be internalized transphobia or may be some other manifestation of just dis- -- emotional and psychological discomfort with continuing to have a body part that you don't want to have or wishing you had one that you don't. The mental health crises appear to be in part -- again, it's like that cork on the ocean thing. The gender dysphoria is going to be -- I think for her it has ebbed and flowed to some degree, but I don't think there's a time when it hasn't been present as far as I can tell. But the interactions with authority figures who give her bad news, who she perceives as delaying things, or when she has feelings of abandonment, that also taps into, I think, some trauma-related issues